

**UNMH Nurse Practitioner & Physician Assistant (CNP & PA)**  
**Oncology Special Procedures (Appendix L)**

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

- Initial privileges (initial appointment)
- Renewal of privileges (reappointment)
- Expansion of privileges (modification)

*All new applicants must meet the following requirements as approved by the UNMH Board of Trustees effective: 06/27/2014*

### **INSTRUCTIONS**

**Applicant:** Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

**Department Chair:** Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

### **OTHER REQUIREMENTS**

1. Note that privileges granted may only be exercised at UNM Hospitals and clinics that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.
2. This document defines qualifications to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

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### ***Special Procedures in Oncology***

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**Criteria:** Currently privileged with core privileges as a CNP or PA at UNM Hospitals and clinics. Successful completion of training in requested procedure(s), or documentation of a special course for requested procedure(s) accompanied with demonstrated proctoring for requested procedures with acceptable outcomes.

**Required Current Experience:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 12 months.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of requested procedure(s) with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

### **Qualifications for Bone marrow biopsy**

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**Criteria:** Demonstrated current competence with evidence of training and supervised placements of at least 5 Bone marrow biopsies with acceptable outcomes.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of bone marrow biopsies with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE: *Bone marrow biopsy***

**Requested**

### **Qualifications for Intrathecal chemo via Omayo shunt**

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**Criteria:** Demonstrated current competence with evidence of training and supervised placements of at least 5 intrathecal chemo via omayo shunt procedures with acceptable outcomes.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of intrathecal chemo via omayo shunt procedures with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE: *Intrathecal chemo via Omayo shunt***

**Requested**

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## **Qualifications for Lumbar Puncture**

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**Criteria:** Demonstrated current competence with evidence of training and supervised placements of at least 5 lumbar punctures with acceptable outcomes.

**Renewal of Privilege:** Demonstrated current competence and evidence of performance of an acceptable volume of lumbar punctures with acceptable results in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

**NON-CORE PRIVILEGE: *Lumbar puncture***

**Requested**

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**Acknowledgment of practitioner**

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM Hospitals and clinics, and I understand that:

- a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Clinical Director/Division Chief recommendation(s) (if applicable)**

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and recommend action as presently requested above:

Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

**Department Chair recommendation**

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

- Recommend all requested privileges with the standard professional practice plan
- Recommend privileges with the standard professional practice plan and the following conditions/modifications:
- Do not recommend the following requested privileges:

Privilege Condition/Modification/Explanation

Notes:

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\_\_\_\_\_

Department Chair Signature \_\_\_\_\_ Date \_\_\_\_\_

Criteria approved by UNMH Board of Trustees on 06/27/2014